FINANCIAL POLICY

Thank you for choosing us as your dental care provider. The following is a statement of our financial policy, which we require you to read, agree and sign prior to treatment.

PAYMENT

We require payment in full at the time of service. For your convenience we accept cash, personal checks, Visa, MasterCard, Discover and American Express. We also offer a payment plan through Care Credit or Chase, which will be reviewed with you prior to your treatment. Please understand that payment of your bill is considered part of your treatment, and you will be required to make financial arrangements prior to any work being preformed.

INSURANCE

Submission: As a courtesy we will prepare and submit your insurance forms for reimbursement if we have been given all of the necessary information for submission. We cannot bill your insurance company unless you bring in all of your insurance information. Please keep the following in mind:

- The balance is your responsibility whether your insurance company pays or not.
- Your insurance policy is a contract between you and you insurance company. We are not a party to that contract.
- Please be aware that some and perhaps all of the dental services performed by Flatirons Family Dental may be "non-covered" services and not considered reasonable and necessary under your dental contract.

Patient Portion: Your patient portion will be estimated and due on the day of service. This estimate is based on information received by our staff from your insurance company and is only an approximate amount. Patient portions which are underestimated will be billed immediately after payment is received from you insurance company. Overpayments on accounts will be refunded to the patient. Account balances over 30 days will be subject to additional fees and interest charges of 1.5% per month. Checks which do not clear with your bank will be assessed a $25.00 service charge for reprocessing. Once a check does not clear your bank account, it will no longer be considered as an acceptable form of payment. Account balances that are not satisfied as agreed will be turned over to a collection agency and will be subject to a 30% fee.

I have read the above, and do understand and agree to the financial policy.

Patient Signature/ Legal Guardian Signature **Print Patient Name** **Date**